de: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 600

[CMS-2441-P]

RIN 0938-AU89

Basic Health Program; Federal Funding Methodology for Program Year 2023 and Proposed Changes to Basic Health Program Regulations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This document proposes the methodology and data sources necessary to determine Federal payment amounts to be made for program year 2023 to States that elect to establish a Basic Health Program under the Patient Protection and Affordable Care Act to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Health Insurance Exchanges.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 30 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, refer to file code CMS-2441-P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2441-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2441-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT: Christopher Truffer, (410) 786-1264; or Cassandra Lagorio, (410) 786-4554.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments. CMS will not post on Regulations.gov public comments that make

threats to individuals or institutions or suggest that the commenter will take actions to harm another individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

A. Overview of the Basic Health Program

Section 1331 of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) (collectively referred to as the Affordable Care Act or ACA) provides States with an option to establish a Basic Health Program (BHP). In the States that elect to operate a BHP, the BHP makes affordable health benefits coverage available for individuals under age 65 with household incomes between 133 percent and 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage, or for individuals whose income is below these levels but are lawfully present non-citizens ineligible for Medicaid. For those States that have expanded Medicaid coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), the lower income threshold for BHP eligibility is effectively 138 percent due to the application of a required 5 percent income disregard in determining the upper limits of Medicaid income eligibility (section 1902(e)(14)(I) of the Act).

A BHP is another option for States to provide affordable health benefits to individuals with incomes in the ranges described above. States may find a BHP a useful option for several reasons, including the ability to potentially coordinate standard health plans in the BHP with their Medicaid managed care plans, or to potentially reduce the costs to individuals by lowering premiums or cost-sharing requirements.

Federal funding for a BHP under section 1331(d)(3)(A) of the ACA is based on the amount of the Federal premium tax credit (PTC) allowed and payments to cover required cost-

sharing reductions (CSRs) that would have been provided for the fiscal year to eligible individuals enrolled in BHP standard health plans in the State if such eligible individuals were allowed to enroll in a qualified health plan (QHP) through Health Insurance Exchanges (Exchanges). These funds are paid to trusts established by the States and dedicated to the BHP, and the States then administer the payments to standard health plans within the BHP.

In the March 12, 2014, **Federal Register** (79 FR 14111), we published a final rule entitled the "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity" (hereinafter referred to as the BHP final rule) implementing section 1331 of the ACA, which governs the establishment of BHPs. The BHP final rule established the standards for State and Federal administration of BHPs, including provisions regarding eligibility and enrollment, benefits, cost-sharing requirements and oversight activities. While the BHP final rule codified the overall statutory requirements and basic procedural framework for the funding methodology, it does not contain the specific information necessary to determine Federal payments. We anticipated that the methodology would be based on data and assumptions that would reflect ongoing operations and experience of BHPs, as well as the operation of the Exchanges. For this reason, the BHP final rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual BHP Payment Notice.

In the BHP final rule, we specified that the BHP Payment Notice process would include the annual publication of both a proposed and final BHP payment methodology. The proposed BHP Payment Notice would be published in the **Federal Register** each October, 2 years prior to the applicable program year, and would describe the proposed funding methodology for the relevant BHP year,[1] including how the Secretary of the Department of Health and Human

[1] BHP program years span from January 1 through December 31.

Services (the Secretary) considered the factors specified in section 1331(d)(3) of the ACA, along with the proposed data sources used to determine the Federal BHP payment rates for the applicable program year. The final BHP Payment Notice would be published in the **Federal Register** in February, and would include the final BHP payment methodology, as well as the Federal BHP payment rates for the applicable BHP program year.[2] For example, payment rates in the final BHP Payment Notice published in February 2015 applied to BHP program year 2016, beginning in January 2016. As discussed in section II.D. of this proposed rule, and as referenced in 42 CFR 600.610(b)(2), State data needed to calculate the Federal BHP payment rates for the final BHP Payment Notice must be submitted to CMS.

As described in the BHP final rule, once the final methodology for the applicable program year has been published, we will generally make modifications to the BHP funding methodology on a prospective basis, with limited exceptions. The BHP final rule provided that retrospective adjustments to the State's BHP payment amount may occur to the extent that the prevailing BHP funding methodology for a given program year permits adjustments to a State's Federal BHP payment amount due to insufficient data for prospective determination of the relevant factors specified in the applicable final BHP Payment Notice. For example, the population health factor adjustment described in section II.D.3. of this proposed rule allows for a retrospective adjustment (at the State's option) to account for the impact that BHP may have had on the risk pool and QHP premiums in the Exchange. Additional adjustments could be made to the payment rates to correct errors in applying the methodology (such as mathematical errors).

Under section 1331(d)(3)(ii) of the ACA, the funding methodology and payment rates are expressed as an amount per eligible individual enrolled in a BHP standard health plan (BHP enrollee) for each month of enrollment. These payment rates may vary based on categories or classes of enrollees. Actual payment to a State would depend on the actual enrollment of individuals found eligible in accordance with a State's certified BHP Blueprint eligibility and

---

[2] In section III. of this proposed rule, we propose to modify the publication schedule of the BHP payment notices.

verification methodologies in coverage through the State BHP. A State that is approved to implement a BHP must provide data showing quarterly enrollment of eligible individuals in the various Federal BHP payment rate cells. Such data must include the following:

- Personal identifier;
- Date of birth;
- County of residence;
- Indian status;
- Family size;
- Household income;
- Number of persons in household enrolled in BHP;
- Family identifier;
- Months of coverage;
- Plan information; and
- Any other data required by CMS to properly calculate the payment.

B. The 2018 Final Administrative Order and 2019 through 2022 Payment Methodologies

On October 11, 2017, the Attorney General of the United States provided the Department of Health and Human Services and the Department of the Treasury (the Departments) with a legal opinion indicating that the permanent appropriation at 31 U.S.C. 1324, from which the Departments had historically drawn funds to make CSR payments, cannot be used to fund CSR payments to insurers. In light of this opinion – and in the absence of any other appropriation that could be used to fund CSR payments – the Department of Health and Human Services directed CMS to discontinue CSR payments to issuers until Congress provides for an appropriation. In the absence of a Congressional appropriation for Federal funding for CSR payments, we cannot provide States with a Federal payment attributable to CSRs that would have been paid on behalf of BHP enrollees had they been enrolled in a QHP through an Exchange.

Starting with the payment for the first quarter (Q1) of 2018 (which began on January 1, 2018), we stopped paying the CSR component of the quarterly BHP payments to New York and Minnesota (the States), the only States operating a BHP in 2018. The States then sued the Secretary for declaratory and injunctive relief in the United States District Court for the Southern District of New York. *See New York v. U.S. Dep't of Health & Human Servs.*, No. 18-cv-00683 (RJS) (S.D.N.Y. filed Jan. 26, 2018). On May 2, 2018, the parties filed a stipulation requesting a stay of the litigation so that HHS could issue an administrative order revising the 2018 BHP payment methodology. As a result of the stipulation, the court dismissed the BHP litigation. On July 6, 2018, we issued a Draft Administrative Order on which New York and Minnesota had an opportunity to comment. Each State submitted comments. We considered the States' comments and issued a Final Administrative Order on August 24, 2018[3] (Final Administrative Order) setting forth the payment methodology that would apply to the 2018 BHP program year.

In the November 5, 2019 **Federal Register** (84 FR 59529) (hereinafter referred to as the November 2019 final BHP Payment Notice), we finalized the payment methodologies for BHP program years 2019 and 2020. The 2019 payment methodology is the same payment methodology described in the Final Administrative Order. The 2020 payment methodology is the same methodology as the 2019 payment methodology with one additional adjustment to account for the impact of individuals selecting different metal tier level plans in the Exchange, referred to as the Metal Tier Selection Factor (MTSF).[4] In the August 13, 2020 **Federal Register** (85 FR 49264 through 49280) (hereinafter referred to as the August 2020 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2021. The 2021 payment methodology is the same methodology as the 2020 payment methodology, with one adjustment to the income reconciliation factor (IRF). In the July 7, 2021 **Federal Register**

[3] https://www.medicaid.gov/sites/default/files/2019-11/final-admin-order-2018-revised-payment-methodology.pdf.
[4] "Metal tiers" refer to the different actuarial value plan levels offered on the Exchanges. Bronze-level plans generally must provide 60 percent actuarial value; silver-level 70 percent actuarial value; gold-level 80 percent actuarial value; and platinum-level 90 percent actuarial value. See 45 CFR 156.140.

(86 FR 35615) (hereinafter referred to as the July 2021 final BHP Payment Notice), we finalized the payment methodology for BHP program year 2022. The 2022 payment methodology is the same as the 2021 payment methodology, which the exception of the removal of the Metal Tier Selection Factor. The 2023 proposed payment methodology is the same as the 2022 payment methodology, except for the addition of a factor to account for a State operating a BHP and implementing an approved State Innovation Waiver under section 1332 of the ACA (referred to as a section 1332 waiver throughout this proposed payment methodology). In section III of this proposed rule, we also propose regulation changes related to the publication schedule of the BHP payment notices and recalculation of States' Federal payments due to mathematical errors.

II. Provisions of the Proposed Rule

A. Overview of the Funding Methodology and Calculation of the Payment Amount

Section 1331(d)(3) of the ACA directs the Secretary to consider several factors when determining the Federal BHP payment amount, which, as specified in the statute, must equal 95 percent of the value of the PTC allowed and CSRs that would have been paid on behalf of BHP enrollees had they enrolled in a QHP through an Exchange. Thus, the BHP funding methodology is designed to calculate the PTC and CSRs as consistently as possible and in general alignment with the methodology used by Exchanges to calculate advance payments of the PTC (APTC) and CSRs, and the methodology used to calculate PTC under 26 U.S.C. 36B, for the tax year. In general, we have relied on values for factors in the payment methodology specified in statute or other regulations as available, and have developed values for other factors not otherwise specified in statute, or previously calculated in other regulations, to simulate the values of the PTC allowed and CSRs that would have been paid on behalf of BHP enrollees if they had enrolled in QHPs offered through an Exchange. In accordance with section 1331(d)(3)(A)(iii) of the ACA, the final funding methodology must be certified by the Chief Actuary of CMS, in consultation with the Office of Tax Analysis (OTA) of the Department of the Treasury, as having met the requirements of section 1331(d)(3)(A)(ii) of the ACA.

Section 1331(d)(3)(A)(ii) of the ACA specifies that the payment determination shall take into account all relevant factors necessary to determine the value of the PTC allowed and CSRs that would have been paid on behalf of eligible individuals, including but not limited to, the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a QHP through an Exchange, and whether any reconciliation of APTC and CSR would have occurred if the enrollee had been so enrolled. Under all previous payment methodologies, the total Federal BHP payment amount has been calculated using multiple rate cells in each State. Each rate cell represents a unique combination of age range (if applicable), geographic area, coverage category (for example, self-only or two-adult coverage through the BHP), household size, and income range as a percentage of FPL, and there is a distinct rate cell for individuals in each coverage category within a particular age range who reside in a specific geographic area and are in households of the same size and income range. The BHP payment rates developed also are consistent with the State's rules on age rating. Thus, in the case of a State that does not use age as a rating factor on an Exchange, the BHP payment rates would not vary by age.

Under the methodology finalized in the July 2021 final BHP Payment Notice, the rate for each rate cell is calculated in 2 parts. The first part is equal to 95 percent of the estimated PTC that would have been allowed if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. The second part is equal to 95 percent of the estimated CSR payment that would have been made if a BHP enrollee in that rate cell had instead enrolled in a QHP in an Exchange. These two parts are added together and the total rate for that rate cell would be equal to the sum of the PTC and CSR rates. As noted in the July 2021 final BHP Payment Notice, we currently assign a value of zero to the CSR portion of the BHP payment rate calculation, because there is presently no available appropriation from which we can make the CSR portion of any BHP

payment. We seek comment on the following proposals.

We propose that Equation (1) would be used to calculate the estimated PTC for eligible individuals enrolled in the BHP in each rate cell. We note that throughout this proposed rule, when we refer to enrollees and enrollment data, we mean data regarding individuals who are enrolled in the BHP who have been found eligible for the BHP using the eligibility and verification requirements that are applicable in the State's most recent certified Blueprint. By applying the equations separately to rate cells based on age (if applicable), income and other factors, we effectively take those factors into account in the calculation. In addition, the equations reflect the estimated experience of individuals in each rate cell if enrolled in coverage through an Exchange, taking into account additional relevant variables. Each of the variables in the equations is defined in this section, and further detail is provided later in this section of this proposed rule. In addition, we describe in Equation (2a) and Equation (2b) (below) how we propose to calculate the adjusted reference premium that is used in Equation (1).

Equation 1: Estimated PTC by rate cell

We propose that the estimated PTC, on a per enrollee basis, would continue to be calculated for each rate cell for each State based on age range (if applicable), geographic area, coverage category, household size, and income range. The PTC portion of the rate would be calculated in a manner consistent with the methodology used to calculate the PTC for persons enrolled in a QHP as defined in 26 CFR 1.36B-3, with five adjustments. First, the PTC portion of the rate for each rate cell would represent the mean, or average, expected PTC that would be paid on behalf of all persons in the rate cell, rather than being calculated for each individual enrollee. Second, the reference premium (RP) (described in section II.D.1. of this proposed rule) used to calculate the PTC would be adjusted for the BHP population health status, and in the case of a State that elects to use 2022 premiums for the basis of the BHP Federal payment, for the projected change in the premium from 2022 to 2023, to which the rates announced in the final payment methodology would apply. These adjustments are described in Equation (2a) and

Equation (2b). Third, the PTC would be adjusted prospectively to reflect the mean, or average, net expected impact of income reconciliation on the combination of all persons enrolled in the BHP; this adjustment, the IRF, as described in section II.D.6. of this proposed rule, would account for the impact on the PTC that would have occurred had such reconciliation been performed. Finally, the rate is multiplied by 95 percent, consistent with section 1331(d)(3)(A)(i) of the ACA. We note that in the situation where the average contribution amount of an enrollee would exceed the adjusted reference premium, we would calculate the PTC to be equal to 0 and would not allow the value of the PTC to be negative.

We propose using Equation (1) to calculate the PTC rate, consistent with the methodology described above:

$$\textbf{Equation (1): } PTC_{a,g,c,h,i} = \left[ARP_{a,g,c} - \frac{\sum_j I_{h,i,j} \times PTCF_{h,i,j}}{n} \right] \times IRF \times 95\%$$

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

h = Household size

i = Income range (as percentage of FPL)

$ARP_{a,g,c}$ = Adjusted reference premium

$I_{h,i,j}$ = Income (in dollars per month) at each 1 percentage-point increment of FPL

$j = j^{th}$ percentage-point increment FPL

n = Number of income increments used to calculate the mean PTC

$PTCF_{h,i,j}$ = Premium tax credit formula percentage

IRF = Income reconciliation factor

Equation (2a) and Equation (2b): Adjusted Reference Premium Variable (used in Equation 1)

As part of the calculations for the PTC component, we propose to continue to calculate

the value of the adjusted reference premium as described below. Consistent with the existing approach, we are proposing to allow States to choose between using the actual current year premiums or the prior year's premiums multiplied by the premium trend factor (PTF) (as described in section II.E. of this proposed rule). Below we describe how we would continue to calculate the adjusted reference premium under each option.

In the case of a State that elected to use the reference premium (RP) based on the current program year (for example, 2023 premiums for the 2023 program year), we propose to calculate the value of the adjusted reference premium as specified in Equation (2a). The adjusted reference premium will be equal to the RP, which would be based on the second lowest cost silver plan premium in the applicable program year, multiplied by the BHP population health factor (PHF) (described in section II.D.3. of this proposed rule), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs through an Exchange would have had on the average QHP premium, and multiplied by the PAF (described in section II.D.2. of this proposed rule), which would account for the change in silver-level premiums due to the discontinuance of CSR payments. We also propose to multiply this by the section 1332 waiver factor (WF) (described in section II.D.7 of this proposed rule), as applicable.

$$\textbf{Equation (2a)}: \quad ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF \times WF_g$$

$ARP_{a,g,c}$ = Adjusted reference premium

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

PAF = Premium adjustment factor

WF_g = Section 1332 waiver factor

In the case of a State that elected to use the RP based on the prior program year (for

example, 2022 premiums for the 2023 program year, as described in more detail in section II.E. of this proposed rule), we propose to calculate the value of the adjusted reference premium as specified in Equation (2b). The adjusted reference premium will be equal to the RP, which would be based on the second lowest cost silver plan premium in 2022, multiplied by the BHP PHF (described in section II.D.3. of this proposed rule), which would reflect the projected impact that enrolling BHP-eligible individuals in QHPs on an Exchange would have had on the average QHP premium, multiplied by the PAF (described in section II.D.2. of this proposed rule), which would account for the change in silver-level premiums due to the discontinuance of CSR payments, and multiplied by the PTF (described in section II.E. of this proposed rule), which would reflect the projected change in the premium level between 2022 and 2023. We also propose to multiply this by the WF (described in section II.D.7. of this proposed rule).

$$\textbf{Equation (2b)}: \quad \boldsymbol{ARP_{a,g,c} = RP_{a,g,c} \times PHF \times PAF \times PTF \times WF_g}$$

$ARP_{a,g,c}$ = Adjusted reference premium

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

$RP_{a,g,c}$ = Reference premium

PHF = Population health factor

PAF = Premium adjustment factor

PTF = Premium trend factor

WF_g = Section 1332 waiver factor

Equation 3: Determination of Total Monthly Payment for BHP Enrollees in Each Rate Cell

In general, the rate for each rate cell would be multiplied by the number of BHP enrollees in that cell (that is, the number of enrollees that meet the criteria for each rate cell) to calculate the total monthly BHP payment. This calculation is shown in Equation (3).

$$\textbf{Equation (3)}: \boldsymbol{PMT = \sum \left[(PTC_{a,g,c,h,i} + CSR_{a,g,c,h,i}) \times E_{a,g,c,h,i} \right]}$$

PMT = Total monthly BHP payment

$PTC_{a,g,c,h,i}$ = Premium tax credit portion of BHP payment rate

$CSR_{a,g,c,h,i}$ = Cost sharing reduction portion of BHP payment rate

$E_{a,g,c,h,i}$ = Number of BHP enrollees

a = Age range

g = Geographic area

c = Coverage status (self-only or applicable category of family coverage) obtained through BHP

h = Household size

i = Income range (as percentage of FPL)

In this equation, we would assign a value of zero to the CSR part of the BHP payment rate calculation ($\boldsymbol{CSR_{a,g,c,h,i}}$) because there is presently no available appropriation from which we can make the CSR portion of any BHP payment. In the event that an appropriation for CSR payments for 2023 is made, we would determine whether and how to modify the CSR part of the BHP payment rate calculation ($\boldsymbol{CSR_{a,g,c,h,i}}$) or the PAF in the payment methodology.

B. Federal BHP Payment Rate Cells

Consistent with the previous payment methodologies, we propose that a State implementing a BHP will provide us an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program quarter, by applicable rate cell, prior to the first quarter and each subsequent quarter of program operations until actual enrollment data is available. Upon our approval of such estimates as reasonable, we will use those estimates to calculate the prospective payment for the first and subsequent quarters of program operation until the State provides us with actual enrollment data for those periods. The actual enrollment data is required to calculate the final BHP payment amount and make any necessary reconciliation adjustments to the prior quarters' prospective payment amounts due to differences between projected and actual enrollment. Subsequent quarterly deposits to the State's trust fund would be based on the most recent actual enrollment data submitted to us. Actual enrollment data must be based on

individuals enrolled for the quarter who the State found eligible and whose eligibility was verified using eligibility and verification requirements as agreed to by the State in its applicable BHP Blueprint for the quarter that enrollment data is submitted. Procedures will ensure that Federal payments to a State reflect actual BHP enrollment during a year, within each applicable category, and prospectively determined Federal payment rates for each category of BHP enrollment, with such categories defined in terms of age range (if applicable), geographic area, coverage status, household size, and income range, as explained above.

We propose requiring the use of certain rate cells as part of the proposed methodology. For each State, we propose using rate cells that separate the BHP population into separate cells based on the five factors described as follows:

Factor 1--Age: We propose to continue separating enrollees into rate cells by age (if applicable), using the following age ranges that capture the widest variations in premiums under HHS's Default Age Curve: [5]

- Ages 0-20.
- Ages 21-34.
- Ages 35-44.
- Ages 45-54.
- Ages 55-64.

[5] This curve is used to implement the ACA's 3:1 limit on age-rating in States that do not create an alternative rate structure to comply with that limit. The curve applies to all individual market plans, both within and outside the Exchange. The age bands capture the principal allowed age-based variations in premiums as permitted by this curve. The default age curve was updated for plan or policy years beginning on or after January 1, 2018 to include different age rating factors between children 0-14 and for persons at each age between 15 and 20. More information is available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf. Both children and adults under age 21 are charged the same premium. For adults age 21-64, the age bands in this notice divide the total age-based premium variation into the three most equally-sized ranges (defining size by the ratio between the highest and lowest premiums within the band) that are consistent with the age-bands used for risk-adjustment purposes in the HHS-Developed Risk Adjustment Model. For such age bands, see HHS-Developed Risk Adjustment Model Algorithm "Do It Yourself (DIY)" Software Instructions for the 2018 Benefit Year, April 4, 2019 Update, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-CY2018-DIY-instructions.pdf.

This proposed provision is unchanged from the current methodology.[6]

Factor 2--Geographic area: For each State, we propose separating enrollees into rate cells by geographic areas within which a single RP is charged by QHPs offered through the State's Exchange. Multiple, non-contiguous geographic areas would be incorporated within a single cell, so long as those areas share a common RP.[7] This proposed provision is also unchanged from the current methodology.

Factor 3--Coverage status: We propose to continue separating enrollees into rate cells by coverage status, reflecting whether an individual is enrolled in self-only coverage or persons are enrolled in family coverage through the BHP, as provided in section 1331(d)(3)(A)(ii) of the ACA. Among individuals enrolled in family coverage through the BHP, separate rate cells, as explained below, would apply based on whether such coverage involves two adults alone or whether it involves children. This proposed provision is unchanged from the current methodology.

Factor 4--Household size: We propose to continue the current methods for separating enrollees into rate cells by household size that States use to determine BHP enrollees' household income as a percentage of the FPL under § 600.320 (Determination of eligibility for and enrollment in a standard health plan). We propose to require separate rate cells for several specific household sizes. For each additional member above the largest specified size, we propose to publish instructions for how we would develop additional rate cells and calculate an appropriate payment rate based on data for the rate cell with the closest specified household size. We propose to publish separate rate cells for household sizes of 1 through 10. This proposed provision is unchanged from the current methodology.

---

[6] In this document, references to the "current methodology" refer to the 2022 program year methodology as outlined in the 2022 final BHP Payment Notice.

[7] For example, a cell within a particular State might refer to "County Group 1," "County Group 2," etc., and a table for the State would list all the counties included in each such group. These geographic areas are consistent with the geographic areas established under the 2014 Market Reform Rules. They also reflect the service area requirements applicable to QHPs, as described in 45 CFR 155.1055, except that service areas smaller than counties are addressed as explained in this notice.

Factor 5--Household Income: For households of each applicable size, we propose to continue the current methods for creating separate rate cells by income range, as a percentage of FPL. The PTC that a person would receive if enrolled in a QHP through an Exchange varies by household income, both in level and as a ratio to the FPL. Thus, we propose that separate rate cells would be used to calculate Federal BHP payment rates to reflect different bands of income measured as a percentage of FPL. We propose using the following income ranges, measured as a percentage of the FPL:

- 0 to 50 percent of the FPL.
- 51 to 100 percent of the FPL.
- 101 to 138 percent of the FPL.[8]
- 139 to 150 percent of the FPL.
- 151 to 175 percent of the FPL.
- 176 to 200 percent of the FPL.

This proposed provision is unchanged from the current methodology.

These rate cells would be used only to calculate the Federal BHP payment amount. A State implementing a BHP would not be required to use these rate cells or any of the factors in these rate cells as part of the State payment to the standard health plans participating in the BHP or to help define BHP enrollees' covered benefits, premium costs, or out-of-pocket cost-sharing levels.

Consistent with the current methodology, we propose using averages to define Federal payment rates, both for income ranges and age ranges (if applicable), rather than varying such rates to correspond to each individual BHP enrollee's age (if applicable) and income level. We believe that the proposed approach will increase the administrative feasibility of making Federal BHP payments and reduce the likelihood of inadvertently erroneous payments resulting from

[8] The three lowest income ranges would be limited to lawfully present immigrants who are ineligible for Medicaid because of immigration status.

highly complex methodologies. We also believe this approach should not significantly change Federal payment amounts since, within applicable ranges, the BHP-eligible population is distributed relatively evenly.

The number of factors contributing to rate cells, when combined, can result in over 350,000 rate cells, which can increase the complexity when generating quarterly payment amounts. In future years, and in the interest of administrative simplification, we will consider whether to combine or eliminate certain rate cells.

C. Sources and State Data Considerations

To the extent possible, unless otherwise provided, we intend to continue to use data submitted to the Federal government by QHP issuers seeking to offer coverage through the Exchange in the relevant BHP State to perform the calculations that determine Federal BHP payment cell rates.

States operating a State Exchange in the individual market, however, must provide certain data, including premiums for second lowest cost silver plans, by geographic area, for CMS to calculate the Federal BHP payment rates in those States. We propose that States operating BHPs interested in obtaining the applicable 2023 program year Federal BHP payment rates for its State must submit such data accurately, completely, and as specified by CMS, by no later than October 15, 2022. If additional State data (that is, in addition to the second lowest cost silver plan premium data) are needed to determine the Federal BHP payment rate, such data must be submitted in a timely manner, and in a format specified by us to support the development and timely release of annual BHP Payment Methodologies. The specifications for data collection to support the development of BHP payment rates are published in CMS guidance and are available on the Basic Health Program page of Medicaid.gov, https://www.medicaid.gov/sites/default/files/2019-11/premium-data-collection-tool.zip.

States operating a BHP must submit enrollment data to us on a quarterly basis and should be technologically prepared to begin submitting data at the start of their BHP, starting with the

beginning of the first program year. This differs from the enrollment estimates used to calculate the initial BHP payment, which States would generally submit to CMS 60 days before the start of the first quarter of the program start date. This requirement is necessary for us to implement the payment methodology that is tied to a quarterly reconciliation based on actual enrollment data.

We propose to continue the policy first adopted in the 2016 final BHP Payment Methodology that in States that have BHP enrollees who do not file Federal tax returns (non-filers), the State must develop a methodology to determine the enrollees' household income and household size consistently with Exchange requirements.[9] The State must submit this methodology to us at the time of their Blueprint submission. We reserve the right to approve or disapprove the State's methodology to determine household income and household size for non-filers if the household composition and/or household income resulting from application of the methodology are different from what typically would be expected to result if the individual or head of household in the family were to file a tax return. States currently operating a BHP that wish to change the methodology for non-filers must submit a revised Blueprint outlining the revisions to its methodology, consistent with § 600.125.

In addition, as the Federal payments are determined quarterly and the enrollment data is required to be submitted by the States to us quarterly, we propose that the quarterly payment be based on the characteristics of the enrollee at the beginning of the quarter (or their first month of enrollment in the BHP in each quarter). Thus, if an enrollee were to experience a change in county of residence, household income, household size, or other factors related to the BHP payment determination during the quarter, the payment for the quarter would be based on the data as of the beginning of the quarter (or their first month of enrollment in the BHP in the applicable quarter). Payments would still be made only for months that the person is enrolled in and eligible for the BHP. We do not anticipate that this would have a significant effect on the

[9] See 81 FR at 10097.

Federal BHP payment. The States must maintain data that is consistent with CMS' verification requirements, including auditable records for each individual enrolled, indicating an eligibility determination and a determination of income and other criteria relevant to the payment methodology as of the beginning of each quarter.

Consistent with § 600.610 (Secretarial determination of BHP payment amount), the State is required to submit certain data in accordance with this notice. We require that this data be collected and validated by States operating a BHP, and that this data be submitted to CMS.

D. Discussion of Specific Variables Used in Payment Equations

1. Reference Premium (RP)

To calculate the estimated PTC that would be allowed if BHP-eligible individuals enrolled in QHPs through an Exchange, we must calculate a RP because the PTC is based, in part, on the premiums for the applicable second lowest cost silver plan as explained in section II.D.5. of this proposed rule, regarding the premium tax credit formula (PTCF). The proposed method is unchanged from the current methodology except to update the reference years, and to provide additional methodological details to simplify calculations and to deal with potential ambiguities. Accordingly, for the purposes of calculating the BHP payment rates, the RP, in accordance with 26 U.S.C. 36B(b)(3)(C), is defined as the adjusted monthly premium for an applicable second lowest cost silver plan. The applicable second lowest cost silver plan is defined in 26 U.S.C. 36B(b)(3)(B) as the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides that is offered through the same Exchange. We propose to use the adjusted monthly premium for an applicable second lowest cost silver plan in the applicable program year (2023) as the RP (except in the case of a State that elects to use the prior plan year's premium as the basis for the Federal BHP payment for 2023, as described in section II.E. of this proposed rule).

The RP would be the premium applicable to non-tobacco users. This is consistent with the provision in 26 U.S.C. 36B(b)(3)(C) that bases the PTC on premiums that are adjusted for

age alone, without regard to tobacco use, even for States that allow insurers to vary premiums based on tobacco use in accordance with 42 U.S.C. 300gg(a)(1)(A)(iv).

Consistent with the policy set forth in 26 CFR 1.36B-3(f)(7), to calculate the PTC for those enrolled in a QHP through an Exchange, we propose not to update the payment methodology, and subsequently the Federal BHP payment rates, in the event that the second lowest cost silver plan used as the RP, or the lowest cost silver plan, changes (that is, terminates or closes enrollment during the year).

The applicable second lowest cost silver plan premium will be included in the BHP payment methodology by age range (if applicable), geographic area, and self-only or applicable category of family coverage obtained through the BHP.

We note that the choice of the second lowest cost silver plan for calculating BHP payments would rely on several simplifying assumptions in its selection. For the purposes of determining the second lowest cost silver plan for calculating PTC for a person enrolled in a QHP through an Exchange, the applicable plan may differ for various reasons. For example, a different second lowest cost silver plan may apply to a family consisting of two adults, their child, and their niece than to a family with two adults and their two children, because one or more QHPs in the family's geographic area might not offer family coverage that includes the niece. We believe that it would not be possible to replicate such variations for calculating the BHP payment and believe that in the aggregate, they would not result in a significant difference in the payment. Thus, we propose to use the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category.

This choice of RP relies on an assumption about enrollment in the Exchanges. In the payment methodologies for program years 2015 through 2019, we had assumed that all persons enrolled in the BHP would have elected to enroll in a silver level plan if they had instead enrolled in a QHP through an Exchange (and that the QHP premium would not be lower than the value of the PTC). In the November 2019 final BHP Payment Notice, we continued to use the

second-lowest cost silver plan premium as the RP, but for the 2020 payments we changed the assumption about which metal tier plans enrollees would choose, by adding the MTSF. In the 2021 payment methodology, we continued to apply the MTSF. In the final 2022 payment methodology, we removed the MTSF. We propose to continue the approach taken in the final 2022 payment methodology and not apply the MTSF in this proposed 2023 payment methodology.

We do not believe it is appropriate to adjust the payment for an assumption that some BHP enrollees would not have enrolled in QHPs for purposes of calculating the BHP payment rates, since section 1331(d)(3)(A)(ii) of the ACA requires the calculation of such rates as if the enrollee had enrolled in a QHP through an Exchange.

The applicable age bracket (if any) will be one dimension of each rate cell. We propose to assume a uniform distribution of ages and estimate the average premium amount within each rate cell. We believe that assuming a uniform distribution of ages within these ranges is a reasonable approach to determining the total monthly payment for BHP enrollees. We also believe this approach would avoid potential inaccuracies that could otherwise occur in relatively small payment cells if age distribution were measured by the number of persons eligible or enrolled. We have used this approach starting since the 2015 program year. We believe that other approaches (than assuming uniform age distribution) could skew the calculation of the payment rates for each rate cell. Given the number of rate cells and the fact that in some cases the number of enrollees in a cell may be small (particularly for less common family sizes, smaller counties, etc.), we believe that using estimates of age distribution or historical data could skew results. We also believe a uniform age distribution is reasonably simple to use and avoids increasing burden on States to report data to CMS. We have found this approach reliable to date.

We propose to use geographic areas based on the rating areas used in the Exchanges. We propose to define each geographic area so that the RP is the same throughout the geographic area. When the RP varies within a rating area, we propose defining geographic areas as

aggregations of counties with the same RP. Although plans are allowed to serve geographic areas smaller than counties after obtaining our approval, we propose that no geographic area, for purposes of defining BHP payment rate cells, will be smaller than a county. We believe that the benefits of simplifying both the calculation of BHP payment rates and the operation of the BHP justify any impacts on Federal payment levels.

Finally, in terms of the coverage category, we propose that Federal payment rates only recognize self-only and two-adult coverage, with exceptions that account for children who are potentially eligible for the BHP. First, in States that set the upper income threshold for children's Medicaid and CHIP eligibility below 200 percent of FPL (based on modified adjusted gross income (MAGI)), children in households with incomes between that threshold and 200 percent of FPL would be potentially eligible for the BHP. Currently, the only States in this category are Idaho and North Dakota.[10] Second, the BHP would include lawfully present immigrant children with household incomes at or below 200 percent of FPL in States that have not exercised the option under sections 1903(v)(4)(A)(ii) and 2107(e)(1)(E) of the Act to qualify all otherwise eligible, lawfully present immigrant children for Medicaid and CHIP. States that fall within these exceptions would be identified based on their Medicaid and CHIP State Plans, and the rate cells would include appropriate categories of BHP family coverage for children. For example, Idaho's Medicaid and CHIP eligibility is limited to families with MAGI at or below 185 percent FPL. If Idaho implemented a BHP, Idaho children with household incomes between 185 and 200 percent could qualify. In other States, BHP eligibility will generally be restricted to adults, since children who are citizens or lawfully present immigrants and live in households with incomes at or below 200 percent of FPL will qualify for Medicaid or CHIP, and thus be ineligible for a BHP under section 1331(e)(1)(C) of the ACA, which limits a BHP to individuals who are ineligible for minimum essential coverage (as defined in 26 U.S.C. 5000A(f)).

2. Premium Adjustment Factor (PAF)

---

[10] CMCS. "State Medicaid, CHIP and BHP Income Eligibility Standards Effective July 1, 2021."

The PAF considers the premium increases in other States that took effect after we discontinued payments to issuers for CSRs provided to enrollees in QHPs offered through Exchanges. Despite the discontinuance of Federal payments for CSRs, QHP issuers are required to provide CSRs to eligible enrollees. As a result, many QHP issuers increased the silver-level plan premiums to account for those additional costs; adjustments and how those were applied (for example, to only silver-level plans or to all metal tier plans) varied across States. For the States operating BHPs in 2018, the increases in premiums were relatively minor, because the majority of enrollees eligible for CSRs (and all who were eligible for the largest CSRs) were enrolled in the BHP and not in QHPs on the Exchanges, and therefore issuers in BHP States did not significantly raise premiums to cover costs related to HHS not making CSR payments.

In the Final Administrative Order and the 2019 through 2022 final BHP Payment Notices, we incorporated the PAF into the BHP payment methodologies to capture the impact of how other States responded to us ceasing to make CSR payments. We propose to include the PAF in the 2023 payment methodology and to calculate it in the same manner as in the Final Administrative Order. In the event that an appropriation for CSR payments is made for 2023, we would determine whether and how to modify the PAF in the payment methodology.

Under the Final Administrative Order[11], we calculated the PAF by using information sought from QHP issuers in each State and the District of Columbia, and we determined the premium adjustment that the responding QHP issuers made to each silver level plan in 2018 to account for the discontinuation of CSR payments to QHP issuers. Based on the data collected, we estimated the median adjustment for silver level QHPs nationwide (excluding those in the two BHP States). To the extent that QHP issuers made no adjustment (or the adjustment was zero), this would be counted as zero in determining the median adjustment made to all silver level QHPs nationwide. If the amount of the adjustment was unknown—or we determined that it

[11] https://www.medicaid.gov/sites/default/files/2019-11/final-admin-order-2018-revised-payment-methodology.pdf.

should be excluded for methodological reasons (for example, the adjustment was negative, an outlier, or unreasonable)—then we did not count the adjustment towards determining the median adjustment.[12] The median adjustment for silver level QHPs is the nationwide median adjustment.

For each of the two BHP States, we determined the median premium adjustment for all silver level QHPs in that State, which we refer to as the State median adjustment. The PAF for each BHP State equaled one plus the nationwide median adjustment divided by one plus the State median adjustment for the BHP State. In other words,

PAF = (1 + Nationwide Median Adjustment) ÷ (1 + State Median Adjustment).

To determine the PAF described above, we sought to collect QHP information from QHP issuers in each State and the District of Columbia to determine the premium adjustment those issuers made to each silver level plan offered through the Exchange in 2018 to account for the end of CSR payments. Specifically, we sought information showing the percentage change that QHP issuers made to the premium for each of their silver level plans to cover benefit expenditures associated with the CSRs, given the lack of CSR payments in 2018. This percentage change was a portion of the overall premium increase from 2017 to 2018.

According to our 2018 records, there were 1,233 silver-level QHPs operating on Exchanges in 2018. Of these 1,233 QHPs, 318 QHPs (25.8 percent) responded to our request for the percentage adjustment applied to silver-level QHP premiums in 2018 to account for the discontinuance of HHS making CSR payments. These 318 QHPs operated in 26 different States, with 10 of those States running State based exchanges (SBEs) (while we requested information only from QHP issuers in States serviced by an FFE, many of those issuers also had QHPs in State Exchanges and submitted information for those States as well). Thirteen of these 318 QHPs were in New York (and none were in Minnesota). Excluding these 13 QHPs from the

[12] Some examples of outliers or unreasonable adjustments include (but are not limited to) values over 100 percent (implying the premiums doubled or more because of the adjustment), values more than double the otherwise highest adjustment, or non-numerical entries.

analysis, the nationwide median adjustment was 20.0 percent. Of the 13 QHPs in New York that responded, the State median adjustment was 1.0 percent. We believe that this is an appropriate adjustment for QHPs in Minnesota, as well, based on the observed changes in New York's QHP premiums in response to the discontinuance of CSR payments (and the operation of the BHP in that State) and our analysis of expected QHP premium adjustments for States with BHPs. We calculated the proposed PAF as (1 + 20%) ÷ (1 + 1%) (or 1.20/1.01), which results in a value of 1.188.

We propose to continue to set the PAF to 1.188 for program year 2023, with one limited exception as described below. We believe that this value for the PAF continues to reasonably account for the increase in silver-level premiums experienced in non-BHP States that took effect after the discontinuance of the CSR payments. We believe that the impact of the increase in silver-level premiums in 2023 can reasonably be expected to be similar to that in 2018, because the discontinuation of CSR payments has not changed. Moreover, we believe that States and QHP issuers have not significantly changed the manner and degree to which they are increasing QHP silver-level premiums to account for the discontinuation of CSR payments since 2018, and we expect the same for 2023.

In addition, the percentage difference between the average second lowest-cost silver level QHP and the bronze-level QHP premiums has not changed significantly since 2018, and we do not expect a significant change for 2023. In 2018, the average second lowest-cost silver level QHP premium was 41.1 percent higher than the average lowest-cost bronze-level QHP premium ($481 and $341, respectively). In 2022, (the latest year for which premiums have been published), the difference was modestly lower; the average second lowest-cost silver-level QHP premium was 33.1 percent higher than the average lowest-cost bronze-level QHP premium ($438 and $329, respectively).[13] In contrast, the average second lowest-cost silver-level QHP premium

[13] *See* Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2021," https://www.kff.org/health-reform/State-indicator/average-marketplace-premiums-by-metal-tier/.

was only 23.8 percent higher than the average lowest-cost bronze-level QHP premium in 2017 ($359 and $290, respectively).[14] If there were a significant difference in the amounts that QHP issuers were increasing premiums for silver-level QHPs to account for the discontinuation of CSR payments over time, then we would expect the difference between the bronze-level and silver-level QHP premiums to change significantly over time, and that this would be apparent in comparing the lowest-cost bronze-level QHP premium to the second lowest-cost silver-level QHP premium.

We propose to make one limited exception in setting the value of the PAF, all for States in the first year of implementing a BHP. In the case of a State in the first year of implementing a BHP, if the State chooses to use prior year second lowest cost silver plan (SLCSP) premiums to determine the BHP payment (for example, the 2022 premiums for the 2023 program year), we propose to set the value of the PAF to 1.00. In this case, we believe that adjustment to the QHP premiums to account for the discontinuation of CSR payments would be included fully in the prior year premiums. If the State chooses to use the prior year premiums, then no further adjustment would be necessary for the BHP payments; therefore, the value of the PAF would be 1.00.

3. Population Health Factor (PHF)

We propose that the PHF be included in the methodology to account for the potential differences in the average health status between BHP enrollees and persons enrolled through the Exchanges. To the extent that BHP enrollees would have been enrolled through an Exchange in the absence of a BHP in a State, the exclusion of those BHP enrollees in the Exchange may affect the average health status of the overall population and the expected QHP premiums.

We currently do not believe that there is evidence that the BHP population would have better or poorer health status than the Exchange population. At this time, there continues to be a

[14] See Basic Health Program: Federal Funding Methodology for Program Years 2019 and 2020; Final Methodology, 84 FR 59529 at 59532 (November 5, 2019).

lack of data on the experience in the Exchanges that limits the ability to analyze the potential health differences between these groups of enrollees. More specifically, Exchanges have been in operation since 2014, and two States have operated BHPs since 2015, but data is not available to do the analysis necessary to determine if there are differences in the average health status between BHP and Exchange enrollees. In addition, differences in population health may vary across States. We also do not believe that sufficient data would be available to permit us to make a prospective adjustment to the PHF under § 600.610(c)(2) for the 2023 program year.

Given these analytic challenges and the limited data about Exchange coverage and the characteristics of BHP-eligible consumers, we propose that the PHF continue to be 1.00 for program year 2023.

In previous years BHP payment methodologies, we included an option for States to include a retrospective population health status adjustment. We propose that States be provided with the same option for 2023 to include a retrospective population health status adjustment in the certified methodology, which is subject to our review and approval. This option is described further in section II.F. of this proposed rule. Regardless of whether a State elects to include a retrospective population health status adjustment, we anticipate that, in future years, when additional data becomes available about Exchange coverage and the characteristics of BHP enrollees, we may propose a different PHF.

While the statute requires consideration of risk adjustment payments and reinsurance payments insofar as they would have affected the PTC that would have been allowed for BHP-eligible individuals had they enrolled in QHPs, we are not proposing to require that a BHP's standard health plans receive such payments. As explained in the BHP final rule, BHP standard health plans are not included in the Federally-operated risk adjustment program.[15] Further, standard health plans did not qualify for payments under the transitional reinsurance program established under section 1341 of the ACA for the years the program was operational (2014

[15] See 79 FR at 14131.

through 2016).[16] To the extent that a State operating a BHP determines that, because of the distinctive risk profile of BHP-eligible consumers, BHP standard health plans should be included in mechanisms that share risk with other plans in the State's individual market, the State would need to use other methods for achieving this goal.

4. Household Income (I)

Household income is a significant determinant of the amount of the PTC that is provided for persons enrolled in a QHP through an Exchange. Accordingly, all BHP Payment Methodologies incorporate household income into the calculations of the payment rates through the use of income-based rate cells. We propose defining household income in accordance with the definition in 26 U.S.C. 36B(d)(2)(A) and consistent with the definition in 45 CFR 155.300. Income would be measured relative to the FPL, which is updated periodically in the **Federal Register** by the Secretary under the authority of 42 U.S.C. 9902(2). In our proposed methodology, household size and income as a percentage of FPL would be used as factors in developing the rate cells. We propose using the following income ranges measured as a percentage of FPL:[17]

- 0–50 percent.
- 51–100 percent.
- 101–138 percent.
- 139–150 percent.
- 151-175 percent.
- 176-200 percent.

We further propose to assume a uniform income distribution for each Federal BHP payment cell. We believe that assuming a uniform income distribution for the income ranges

[16] See 45 CFR 153.400(a)(2)(iv) (BHP standard health plans are not required to submit reinsurance contributions), 153.20 (definition of "Reinsurance-eligible plan" as not including "health insurance coverage not required to submit reinsurance contributions"), 153.230(a) (reinsurance payments under the national reinsurance parameters are available only for "Reinsurance-eligible plans").

[17] These income ranges and this analysis of income apply to the calculation of the PTC.

proposed would be reasonably accurate for the purposes of calculating the BHP payment and would avoid potential errors that could result if other sources of data were used to estimate the specific income distribution of persons who are eligible for or enrolled in the BHP within rate cells that may be relatively small.

Thus, when calculating the mean, or average, PTC for a rate cell, we propose to calculate the value of the PTC at each one percentage point interval of the income range for each Federal BHP payment cell and then calculate the average of the PTC across all intervals. This calculation would rely on the PTC formula described in section II.D.5. of this proposed rule.

As the APTC for persons enrolling in QHPs would be calculated during the open enrollment period based on their projected household income for the coverage year, and that income would be measured against the FPL at that time, we propose to adjust the FPL by multiplying the FPL by a projected increase in the CPI-U between the time that the BHP payment rates are calculated and the QHP open enrollment period, if the FPL is expected to be updated during that time. We propose that the projected increase in the CPI-U would be based on the intermediate inflation forecasts from the most recent Old-Age, Survivors, and Disability Insurance (OASDI) and Medicare Trustees Reports. [18]

5. Premium Tax Credit Formula (PTCF)

In Equation 1 described in section II.A.1. of this proposed rule, we propose to use the formula described in 26 U.S.C. 36B(b) to calculate the estimated PTC that would be allowed for a person enrolled in a QHP on an Exchange as part of the BHP payment methodology. This formula is used to determine the contribution amount (the amount of premium that an individual or household theoretically would be required to pay for coverage in a QHP on an Exchange), which is based on (A) the household income; (B) the household income as a percentage of FPL for the family size; and (C) the schedule specified in 26 U.S.C. 36B(b)(3)(A) and shown below.

[18] *See* Table IV A1 from the 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

The difference between the contribution amount and the adjusted monthly premium (that is, the monthly premium adjusted for the age of the enrollee) for the applicable second lowest cost silver plan is the estimated amount of the PTC that would be provided for the enrollee.

The PTC amount allowed for a person enrolled in a QHP through an Exchange is calculated in accordance with the methodology described in 26 U.S.C. 36B(b)(2). The amount is equal to the lesser of the premium for the plan in which the person or household enrolls, or the adjusted premium for the applicable second lowest cost silver plan minus the contribution amount.

The applicable percentage is defined in 26 U.S.C. 36B(b)(3)(A) and 26 CFR 1.36B-3(g) as the percentage that applies to a taxpayer's household income that is within an income tier, increasing on a sliding scale in a linear manner from an initial premium percentage to a final premium percentage. We propose to continue to use applicable percentages to calculate the estimated PTC that would be allowed for a person enrolled in a QHP on an Exchange as part of the BHP payment methodology as part of Equation 1.

The Internal Revenue Service publishes the applicable percentages each year. They are not yet available for 2023, but we propose to apply them to the 2023 payment methodology upon publication.

6. Income Reconciliation Factor (IRF)

For persons who enroll, or enroll a family member, in a QHP through an Exchange for which APTC is paid, a reconciliation is required by 26 U.S.C. 36B(f) following the end of the coverage year. The reconciliation requires the enrolling individual (the taxpayer) to compare the total amount of APTC paid on behalf of the taxpayer or a family member of the taxpayer for the year of coverage to the total amount of PTC allowed for the year of coverage, based on household circumstances shown on the Federal income tax return. If the amount of a taxpayer's PTC exceeds the APTC paid on behalf of the taxpayer, the difference reduces the taxpayer's tax liability for the year of coverage or results in a refund to the extent it exceeds the taxpayer's tax

liability. If the APTC exceeds the PTC allowed, the taxpayer must increase his or her tax liability for the year of coverage by the difference, subject to any limitations in statute or regulation.

Section 1331(e)(2) of the ACA specifies that an individual eligible for the BHP may not be treated as a "qualified individual" under section 1312 of the ACA who is eligible for enrollment in a QHP offered through an Exchange. We are defining "eligible" to mean anyone for whom the State agency or the Exchange assesses or determines, based on the single streamlined application or renewal form, as eligible for enrollment in the BHP. Because APTC is paid only on behalf of individuals enrolled in a QHP, individuals determined or assessed as eligible for a BHP are not eligible for APTC for coverage in the Exchange. Consequently, unlike Exchange enrollees for whom APTC is paid, no reconciliation is required of BHP enrollees, on whom the BHP payment methodology is generally based.

Nonetheless, there may still be differences between a BHP enrollee's household income reported at the beginning of the year and the actual household income for the year. These may include small changes (reflecting changes in hourly wage rates, hours worked per week, and other fluctuations in income during the year) and large changes (reflecting significant changes in employment status, hourly wage rates, or substantial fluctuations in income). There may also be changes in household composition. Thus, we believe that using unadjusted income as reported prior to the BHP program year may result in calculations of estimated PTC that are inconsistent with the actual household incomes of BHP enrollees during the year. Even if the BHP adjusts household income determinations and corresponding claims of Federal payment amounts based on household reports during the year or data from third-party sources, such adjustments may not fully capture the effects of tax reconciliation that BHP enrollees would have experienced had they been enrolled in a QHP through an Exchange with APTC.

Therefore, in accordance with current practice, we propose including in Equation 1 an adjustment, the IRF, that would account for the difference between calculating estimated PTC

using: (a) household income relative to FPL as determined at initial application and potentially revised mid-year under § 600.320, for purposes of determining BHP eligibility and claiming Federal BHP payments; and (b) actual household income relative to FPL for the plan year, as it would be reflected on individual Federal income tax returns. This adjustment would seek prospectively to capture the average effect of income reconciliation aggregated across the BHP population had those BHP enrollees been subject to reconciliation after APTC was paid for coverage through QHPs. Consistent with the methodology used in past years, we propose estimating reconciliation effects based on tax data for 2 years, reflecting income and tax unit composition changes over time among BHP-eligible individuals.

OTA maintains a model that combines detailed tax and other data, including Exchange enrollment and PTC claimed, to project Exchange premiums, enrollment, and tax credits. For each enrollee, this model compares the APTC based on household income and family size estimated at the point of enrollment with the PTC based on household income and family size reported at the end of the tax year. The former reflects the determination using enrollee information furnished by the applicant and tax data furnished by the IRS. The latter would reflect the PTC eligibility based on information on the tax return, which would have been determined if the individual had not enrolled in the BHP. Consistent with prior years, we propose to use the ratio of the reconciled PTC to the initial estimation of PTC as the IRF in Equation (1) for estimating the PTC portion of the BHP payment rate.

We believe that it is appropriate to distinguish between the IRF for Medicaid expansion States and non-Expansion States to remove data for those with incomes under 138 percent of FPL for Medicaid expansion States. This is the same approach that we finalized in the 2021 and 2022 final BHP Payment Notices. Therefore, we propose to set the value of the IRF for States that have expanded Medicaid equal to the value of the IRF for incomes between 138 and 200 percent of FPL and the value of the IRF for States that have not expanded Medicaid equal to the value of the IRF for incomes between 100 and 200 percent of FPL. This gives an IRF of 100.66

percent for States that have expanded Medicaid and 101.63 percent for States that have not expanded Medicaid for program year 2023. Both current States operating a BHP have expanded Medicaid eligibility, and therefore we propose an IRF of 100.66 percent.

We propose to use these values for the IRF in Equations (1) for calculating the PTC portion of the BHP payment rate.

7. Section 1332 Waiver Factor (WF)

Section 1332 of the ACA permits States to apply for a waiver from certain ACA requirements to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance coverage while retaining the basic protections of the ACA. Section 1332 of the ACA authorizes the Secretary of HHS and the Secretary of the Treasury (collectively, the Secretaries) to approve a State's request to waive all or any of the following requirements falling under their respective jurisdictions for health insurance coverage within a State for plan years beginning on or after January 1, 2017: (1) Part I of subtitle D of Title I of the ACA (relating to the establishment of QHPs); (2) Part II of subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through Health Benefit Exchanges); (3) Section 1402 of the ACA (relating to reduced cost sharing for individuals enrolling in QHPs); and (4) Sections 36B (relating to refundable credits for coverage under a QHP), 4980H (relating to shared responsibility for employers regarding health coverage), and 5000A (relating to the requirement to maintain minimum essential coverage) of the Internal Revenue Code (Code).

Under section 1332 of the ACA, the Secretaries may exercise their discretion to approve a request for a section 1332 waiver only if the Secretaries determine that the proposal for the section 1332 waiver meets the following four requirements, referred to as the statutory guardrails: (1) the proposal will provide coverage that is at least as comprehensive as coverage defined in section 1302(b) of the ACA and offered through Exchanges established under title I of the ACA, as certified by the Office of the Actuary of CMS, based on sufficient data from the State and from comparable States about their experience with programs created by the ACA and

the provisions of the ACA that would be waived; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the State's residents as would be provided under title I of the ACA; (3) the proposal will provide coverage to at least a comparable number of the State's residents as would be provided under title I of the ACA; and (4) the proposal will not increase the Federal deficit.[19] The Secretaries retain their discretionary authority under section 1332 of the ACA to deny waivers when appropriate given consideration of the application as a whole, even if an application meets the four statutory guardrails. Sixteen (16) States are operating approved section 1332 waivers in plan year 2022.[20]

Section 1332(a)(3) of the ACA directs the Secretaries to pay pass-through funding to the State for the purpose of implementing the State's section 1332 waivers. Under an approved section 1332 waiver, a State may receive pass-through funding associated with the resulting reductions in Federal spending on Exchange financial assistance (PTC, CSRs, and small business tax credits (SBTC)) consistent with the statute and reduced as necessary to ensure deficit neutrality. These payments are made in compliance with the applicable waiver plans, the specific terms and conditions governing the waiver, and accompanying statutory and regulatory requirements. Specifically, section 1332(a)(3) of the ACA provides that pass-through funding shall be paid to States for purposes of implementing the States' waiver plans. The specific impacts of the waivers on premiums and PTCs vary across States and plan years, depending, in part, on the State's approved section 1332 waiver plan and the design of the State's program.[21] 31 CFR 33.122 and 45 CFR 155.1322 specify that pass-through funding amounts will be

---

[19] See section 1332(b)(1)(A) through (D) of the ACA, 45 CFR 155.1308(f)(3)(iv)(A) through (D), and 31 CFR 33.108(f)(3)(iv)(A) through (D).

[20] See the CMS section 1332 waiver website for information on approved waivers: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

[21] For example, some State reinsurance programs under a section 1332 waiver have reduced Statewide average QHP premiums by 4 percent to 40 percent compared to what premiums would have been without the waiver. See Data Brief on Section 1332 waivers: State-based reinsurance programs available here https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-Aug2021.pdf.

calculated annually by the Departments for States with approved waivers.[22] Additionally, section 1332(a)(4)(B)(v) of the ACA requires that the Secretaries issue regulations that provide a process for periodic evaluations by the Secretaries of the program under the waiver.[23] As implemented by the Departments, the periodic evaluations include evaluation of pass-through funding and associated reporting and methodologies. Information on the pass-through funding amounts is made available publicly on the CMS website.[24]

With regard to a State that operates a BHP and an approved section 1332 waiver, the Federal BHP program can have an impact on section 1332 waiver pass-through funding for that State. For example, the existence of a Federal BHP program impacts aggregate PTC amounts in the State because BHP moves some individuals, who would otherwise be eligible for PTC, out of Exchange coverage. Similarly, as the section 1332 waiver may impact the benchmark QHP premiums and the PTCs in a State, the waiver may also have an effect on the calculation of Federal BHP payments in a State operating a BHP.

If the section 1332 waiver reduces premiums for eligible enrollees, then this can lead to a reduction in the amount of PTC available for eligible enrollees (in particular, if the second lowest-cost silver QHP premium is reduced). While this may not have an effect on particular subsidized QHP enrollees, as their share of the premium would remain unchanged, it would reduce the amount of Federal outlays for PTC. With respect to a State's approved section 1332 waiver, the amount of Federal pass-through funding would equal the difference between (1) the amount, determined annually by the Secretaries, of PTC under section 36B of the Code, the SBTC under section 45R of the Code, or CSRs under part I of subtitle E of the ACA (collectively referred to as Exchange financial assistance) that individuals and small employers

---

[22] See section 1332(a)(3) of the ACA. See also Patient Protection and Affordable Care Act; Updating Payment Parameters and Improving Health Insurance Markets for 2022 and Beyond; Final Rule, 86 FR 53412 at 53482-53483 (Sep 27, 2021).

[23] See 31 CFR 33.128 and 45 CFR 155.1328.

[24] See the CMS section 1332 website for information on pass-through funding here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

in the State would otherwise be eligible for had the State not received approval for its section 1332 waiver and (2) the amount of Exchange financial assistance that individuals and small employers are eligible for with the approved section 1332 waiver in place. The section 1332 waiver pass-through amount would not be increased to account for any savings or decreases in Federal spending other than the reduction in Exchange financial assistance. This pass-through amount for the section 1332 waiver would be reduced by any net increase in Federal spending or net decrease in Federal revenue if necessary to ensure deficit neutrality. The State must use this pass-through funding only for purposes of implementing the plan associated with the State's approved section 1332 waiver. Therefore, in States that operate only an approved section 1332 waiver, the net expected Federal spending is the same, even though the amount of PTC paid by the Federal government is lower.

However, for a State that operates a BHP and a section 1332 waiver, a reduction in the expected Federal PTC payments due to the operation of the waiver leads directly to a reduction in Federal BHP funding to the State under the current BHP methodology. The amount of PTC and CSRs individuals are eligible for in the Exchange is dependent on the cost of the SLCSP premium, and the cost of the SLCSP premium is the basis for determining the amount of Federal funding for its BHP program. Therefore, a reduction in SLCSP premium due to a section 1332 waiver, also reduces the Federal BHP payment. These reductions may be substantial. For example, in Minnesota in 2021, the State's section 1332 waiver resulted in a State-wide average premium reduction of 21.3 percent compared to without the waiver. This led to a similar reduction in PTC paid, and thus a similar reduction in Federal BHP funding. While the PTC allowed for persons eligible for subsidized coverage in the Exchange is lower with the section 1332 waiver in place, the reduction in premiums means that the net benefit to those individuals has not decreased—rather, Federal funding has been shifted from PTC in part to pass-through payments made to the State.

On January 28, 2021, President Biden issued Executive Order (E.O.) 14009 directing

HHS, and the heads of all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA, to review all existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether such agency actions are inconsistent with the policy set forth in section 1 of E.O. 14009 to protect and strengthen the ACA.[25] As part of this review, we considered the impact of approved section 1332 waivers on Federal BHP funding and vice versa in States that elect to operate both a BHP and an approved section 1332 waiver, including the impact in Minnesota, cited above.

We determined it is appropriate to account for the impact of an approved section 1332 waiver when calculating Federal BHP payments. This proposal is necessary for consistency with E.O. 14009 and this Administration's goal of protecting and strengthening the ACA and making high-quality, affordable health care accessible for every American. We believe that it is appropriate to consider the amount of pass-through funding associated with the section 1332 waiver as part of the PTC for the purpose of determining the BHP payments. As described previously, while the PTC allowed may be reduced under the section 1332 waiver, the benefit to the persons eligible for such subsidized coverage has not decreased. Considering the section 1332 pass-through funding as part of the PTC for purposes of determining the BHP payment also counteracts the reduction in Federal BHP funding for States that lawfully exercise the flexibility Congress provided to implement both of the alternative State programs under sections 1331 and 1332 of the ACA. Therefore, we are proposing to add the section 1332 WF for the 2023 BHP payment methodology. We propose that this factor would be calculated as the ratio of (1) the SLCSP premium that would have been in place without the waiver in place for the plan year to (2) the SLCSP in place with the waiver in place for the plan year, as determined for the purposes of calculating the section 1332 waiver pass-through payment.[26] This factor would be calculated specific to each State and geographic area, to the extent that the factor may vary across

[25] 86 FR 7793 (February 2, 2021).

[26] Office of Tax Analysis, Department of Treasury, "Method for Calculation of Section 1332 Reinsurance Waiver 2021 Premium Tax Credit Pass-through Amounts," March 2021.

geographic areas. The SLCSP premiums with and without the waiver, as provided by the State as part of the section 1332 waiver information submitted to the Secretaries, would be reviewed by CMS and used to calculate the factor. In the event that the State's section 1332 waiver SLCSP with- and without -waiver information is not available prior to the calculation of the Federal BHP payments in the fall prior to the start of the BHP program year, we propose to temporarily use values from the prior year's waiver reporting, and then update the payment rates and payments once the values for the applicable plan year are known.[27] In the case that prior -year data is not available, such as in the case of a new waiver or waiver amendment that could delay the timeline by which the State would receive BHP funding, we propose to initially calculate the rates without adjustment for the section 1332 WF, and then to adjust payment rates and payments using the updated waiver data once it becomes available.[28]

We seek public comment on this proposal.

E. State Option to Use Prior Program Year QHP Premiums for BHP Payments

In the interest of allowing States greater certainty in the total BHP Federal payments for a given plan year, we have given States the option to have their final Federal BHP payment rates calculated using a projected adjusted reference premium (that is, using premium data from the prior program year multiplied by the PTF, as described in Equation (2b)). We propose to require States to make their election to have their final Federal BHP payment rates calculated using a projected adjusted reference premium by the later of (1) May 15 of the year preceding the applicable program year or (2) 60 days after the publication of the final notice. Because we are publishing this proposed rule after May 15, 2022, we propose that States be required to inform CMS in writing of their election for the 2023 program year by 60 days after the publication of the final notice.

With the addition of the section 1332 WF, there is the possibility that using the previous

[27] 42 CFR 600.610(c)(2)(iii).
[28] 42 CFR 600.610(c)(2)(iii).

year's QHP premiums multiplied by the PTF could lead to unexpected results if there are significant changes to the State's approved section 1332 waiver, including changes that could occur at the start or the end of the waiver. For example, if a State were to implement a section 1332 waiver in 2023 that lowered premiums significantly, and the State then chose to use the prior year's premiums (that is, 2022 plan year premiums) multiplied by the PTF, this could lead to BHP payment well in excess of what would have been paid in the Exchanges when the WF is added to the methodology. Similarly, if a State were to end its section 1332 waiver and choose to use the prior year's premiums, the BHP payment could be less than what would otherwise be expected.

Therefore, we also propose that in the following cases, the current year QHP premiums would have to be used for calculating BHP payments with regard to section 1332 waivers: (1) a State implements a new section 1332 waiver that begins at the start of the BHP program year; (2) a State ends a section 1332 waiver in the year prior to the start of the BHP program year; or (3) the percentage difference between the with and without waiver premiums used to determine the section 1332 waiver pass-through funding amount (and used to determine the WF) changes by 5 or more percentage points from the prior year. The percentage difference would be measured based on the enrollment-weighted average of the with and without waiver premiums. We believe that these three scenarios (the start of a new waiver, the end of a waiver, and a significant change to a waiver) reflect all relevant scenarios in which changes to a section 1332 waiver would lead to a significant error in the calculation of BHP payments if the prior year premiums were used in the BHP payment methodology. We believe that this proposed requirement to use the current year QHP premiums in these limited circumstances would avoid an incorrect calculation of BHP payments due to changes related to the section 1332 waiver.

We seek public comments on this proposal.

For Equation (2b), we propose to continue to define the PTF, with minor proposed changes in calculation sources and methods, as follows:

PTF: In the case of a State that would elect to use the 2022 premiums as the basis for determining the 2023 BHP payment, it would be appropriate to apply a factor that would account for the change in health care costs between the year of the premium data and the BHP program year. This factor would approximate the change in health care costs per enrollee, which would include, but not be limited to, changes in the price of health care services and changes in the utilization of health care services. This would provide an estimate of the adjusted monthly premium for the applicable SLCSP that would be more accurate and reflective of health care costs in the BHP program year.

For the PTF we propose to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure (NHE) projections, developed by the Office of the Actuary of CMS (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected). Based on these projections, for BHP program year 2023, we propose that the PTF would be 4.6 percent.

We note that the increase in premiums for QHPs from one year to the next may differ from the PTF developed for the BHP funding methodology for several reasons. In particular, we note that the second lowest cost silver plan may be different from 1 year to the next. This may lead to the PTF being greater than or less than the actual change in the premium of the SLCSP.

F. State Option to Include Retrospective State-Specific Health Risk Adjustment in Certified Methodology

To determine whether the potential difference in health status between BHP enrollees and consumers in an Exchange would affect the PTC allowed and risk adjustment payments that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange, we propose to continue to provide States implementing the BHP the option to propose and to implement, as part of the certified methodology, a retrospective adjustment to the Federal BHP payments to reflect the actual value that would be assigned to the PHF (or risk adjustment)

based on data accumulated during that program year for each rate cell.

We acknowledge that there is uncertainty with respect to this factor due to the lack of available data to analyze potential health differences between the BHP and QHP populations, which is why, absent a State election, we propose to use a value for the PHF (see section II.D.3. of this proposed rule) to determine a prospective payment rate which assumes no difference in the health status of BHP enrollees and QHP enrollees. There is considerable uncertainty regarding whether the BHP enrollees will pose a greater risk or a lesser risk compared to the QHP enrollees, how to best measure such risk, the potential effect such risk would have had on PTC, and risk adjustment that would have otherwise been made had BHP enrollees been enrolled in coverage through an Exchange. However, to the extent that a State would develop an approved protocol to collect data and effectively measure the relative risk and the effect on Federal payments of PTC and CSRs, we propose to continue to permit a retrospective adjustment that would measure the actual difference in risk between the two populations to be incorporated into the certified BHP payment methodology and used to adjust payments in the previous year.

For a State electing the option to implement a retrospective population health status adjustment as part of the BHP payment methodology applicable to the State, we propose requiring the State to submit a proposed protocol to CMS, which would be subject to approval by CMS and would be required to be certified by the Chief Actuary of CMS, in consultation with the OTA. We propose to apply the same protocol for the population health status adjustment as what is set forth in guidance in Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015 (https://www.medicaid.gov/sites/default/files/2019-11/risk-adjustment-and-bhp-white-paper.pdf). We propose requiring a State to submit its proposed protocol for the 2023 program year by the later of August 1, 2022, or 60 days after the publication of the final notice. We propose that this submission would also need to include descriptions of how the State would collect the necessary data to determine the adjustment, including any contracting contingences that may be in place with participating standard health

plan issuers. We would provide technical assistance to States as they develop their protocols, as requested. To implement the population health status adjustment, we propose that we will approve the State's protocol by December 31, 2022, for the 2023 program year. Finally, we propose that the State be required to complete the population health status adjustment at the end of the program year based on the approved protocol. After the end of the program year, and once data is made available, we propose to review the State's findings, consistent with the approved protocol, and make any necessary adjustments to the State's Federal BHP payment amounts. If we determine the Federal BHP payments were less than they would have been using the final adjustment factor, we would apply the difference to the State's next quarterly BHP trust fund deposit. If we determine that the Federal BHP payments were more than they would have been using the final reconciled factor, we would subtract the difference from the next quarterly BHP payment to the State.

III. Revisions to Basic Health Program Regulations

The calculation of BHP payment amounts is set forth in § 600.610 and is a prospective quarterly calculation of rates based on estimated or known enrollment data prior to the beginning of the quarter for which the rates are calculated, adjusted by actual enrollment data submitted by States after the end of the quarter. Currently, § 600.610(a) commits the Secretary to publish an annual proposed payment notice in October, and § 600.610(b) requires the Secretary to publish an annual final payment notice the following February, setting forth the BHP payment methodology for the following year.

Over the past several years, minimal changes to the payment methodology have been required, and we no longer view an annual publication of a payment methodology as necessary. Specifically, between 2015 and 2022, only two factors (the PAF and the MTSF) were added to the payment methodology, and one of the factors (the MTSF) was subsequently removed. For 2023, we are proposing to add the section 1332 WF. Other than this year's addition of the proposed section 1332 WF, if finalized, we do not believe that additional factors will be added or

removed on an annual basis as this program has now been in operation for several years. Therefore, we are proposing to revise § 600.610(a)(1) to provide for issuance of payment notices that may be effective for only one or multiple program years, as determined by and subject to the discretion of the Secretary, beginning with the 2023 BHP payment methodology and then going forward. We believe this will be beneficial to States that operate a BHP, as it will provide greater certainty regarding the payment methodology for a given year.

In addition, we are proposing at § 600.610(a)(1) and (b)(1) to change the schedule of publication dates for the proposed and final BHP payment notices. Under the current regulation, CMS must publish a proposed payment notice annually in October and a final notice annually in February. As stated above, we do not believe that the publication of an annual payment notice is necessary. In addition, we do not believe that this schedule allows for adequate time for States and other stakeholders to provide comments and for CMS to carefully consider comments received. Therefore, we propose to revise § 600.610(a)(1) and (b)(1) to remove the specific months in which the proposed and final payment methodologies must be published. We note that in years in which the Secretary determines a new payment methodology needs to be proposed and published, if finalized, we would publish a proposed payment methodology with an opportunity for public comment. We would also publish a final payment methodology in advance of the effective date of the payment methodology. If this proposal is finalized, the 2023 final BHP payment methodology would be in effect until we propose and finalize a revised payment methodology. We would also release subregulatory guidance updating the values of factors needed to calculate the Federal BHP payments in years in which a revised payment methodology is not proposed and finalized.

We are proposing these changes under the authority in section 1331(d)(3)(A)(iii) of the ACA, which requires that the Chief Actuary of CMS, in consultation with OTA, shall certify whether the methodology used to make payments to the States meets the requirements of section 1331(d)(3)(A)(ii) of the ACA.

Under § 600.610(c)(2)(ii), the Secretary will recalculate a State's BHP payment amount upon determination that a mathematical error occurred during the application of the BHP funding methodology. Under this current regulation, it is not permissible to recalculate a State's BHP payment amount upon determining that a mathematical error occurred during the *development* of the applicable BHP funding methodology.

Examples of mathematical errors in the application and/or development of the BHP funding methodology include using the incorrect value of a factor within the BHP payment methodology or using incorrect data to calculate a factor within the BHP payment methodology. Examples of changes that are not mathematical errors under this regulation include the addition or removal of a factor in the BHP payment methodology or a change in the approach for calculating a factor.

As an example of mathematical error in the development of the BHP payment methodology, we recently became aware of an error in calculating the Income Reconciliation Factor (IRF) for program year 2019, resulting in an underpayment of Federal funds to States for their BHPs. In reviewing the model used to calculate the IRF, CMS and OTA found an error in the computation of the IRF. Working with OTA, we have developed a new value for the IRF for 2019. Previously, the IRF for the 2019 BHP payment methodology was 98.03 percent. The corrected value for the IRF for program year 2019 was recalculated as the median of the impact of income reconciliation on PTC for persons with incomes between 100 percent and 200 percent of FPL (102.36 percent) and the impact for persons with incomes between 133 percent and 200 percent of FPL (101.66 percent), which is 102.01 percent. Using the median of the two values is the same approach as we used to calculate the original IRF value in 2019, and the difference between the values is attributable to a mathematical error made during the development of the BHP payment methodology for program year 2019.

Therefore, we are proposing to revise § 600.610(c)(2)(ii) such that a State's payment amount may be retroactively revised due to a mathematical error in the development or

application of the BHP funding methodology. If finalized, we would then be able to recalculate Federal payments to States for 2019 using the updated value of the IRF. We propose this change under the authority in section 1331(d)(3)(B) of the ACA, which requires the Secretary to adjust payments for any fiscal year to reflect any error in the payment amounts under section 1331(d)(3)(A) of the ACA.

We seek public comment on these proposals.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a "collection of information" requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of OMB's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain proposed collection of information requirements.

A. Wage Estimates

To derive average costs for individuals, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates for our salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 1 presents

BLS' mean hourly wage, our estimated cost of fringe benefits and overhead, and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialists	13-1000	38.64	38.64	77.25
General and Operations Managers	11-1021	55.41	55.41	110.82

To derive our proposed cost estimates, we adjusted BLS' mean hourly wage by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Therefore, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate and conservative estimation method.

B. Proposed Information Collection Requirements (ICRs)

The following proposed changes will be submitted to OMB for review under control number 0938-1218 (CMS-10510). We also propose to reinstate that control number as our previous approval was discontinued on August 31, 2017, based on our estimated number of respondents. We are proposing to reinstate the control number based on 5 CFR 1320.3(c)(4)(i) using the standard non-rule PRA process which includes the publication of 60- and 30-day **Federal Register** notices. We anticipate that the initial 60-day notice will publish within 10 business days from the date of publication of this proposed rule.

1. ICRs Regarding the Submission of Estimated and Actual Quarterly Enrollment Data

In sections I.A. and II.B. of this proposed rule, we propose that a State that is approved to implement a BHP must provide CMS with an estimate of the number of BHP enrollees it projects will enroll in the upcoming BHP program quarter, by applicable rate cell, prior to the first quarter and each subsequent quarter of program operations until after actual enrollment data is available. Enrollment data must be submitted by age range (if applicable), geographic area, coverage status, household size, and income range.

We estimate that it would take a business operations specialist 10 hours at $77.25/hr and a general manager 2 hours at $110.82/hr to compile and submit the quarterly estimated enrollment data to CMS. For 2023, we estimate that two States will operate a BHP and will submit the required estimated enrollment data to CMS. In aggregate, we estimate an annual burden of 96 hours (2 States x 12 hr/response x 44 U.S.C. 35014 responses/yr) at a cost of $7,953 [2 States x 4 responses/yr ((10 hr x $77.25/hr) + (2 hr x $110.82/hr)).

In sections I.A. and II.B. of this proposed rule, we also propose that following each BHP program quarter, a State operating a BHP must submit actual enrollment data to CMS. Actual enrollment data must be based on individuals enrolled for the quarter who the State found eligible and whose eligibility was verified using eligibility and verification requirements as agreed to by the State in its applicable BHP Blueprint for the quarter that enrollment data is submitted. Actual enrollment data must include a personal identifier, date of birth, county of residence, Indian status, family size, household income, number of persons in the household enrolled in BHP, family identifier, months of coverage, plan information, and any other data required by CMS to properly calculate the payment. This may include the collection of data related to eligibility for other coverage, marital status (for calculating household composition), or more precise residence location.

We estimate that it would take a business operations specialist 100 hours at $77.25/hr and a general manager 10 hours at $110.82/hr to compile and submit the quarterly actual enrollment data to CMS. For 2023, we estimate that two States will operate a BHP and will submit the required actual enrollment data to CMS. In aggregate, we estimate an annual burden of 880 hours (2 States x 110 hr/response x 4 responses/yr) at a cost of $70,666 [2 States x 4 responses/yr ((100 hr x $77.25/hr) + (10 hr x $110.82/hr)).

2. ICRs Regarding Submission of Qualified Health Plan Data

In section II.C. of this proposed rule, we specify that States operating an SBE in the individual market must provide certain data, including premiums for SLCSPs, by geographic

area, for CMS to calculate the Federal BHP payment rates in those States. States operating BHPs interested in obtaining the applicable 2023 program year Federal BHP payment rates for its State must submit the data to CMS by October 15, 2022.

We estimate that it would take a business operations specialist 20 hours at $77.25/hr and a general manager 2 hours at $110.82/hr to compile and submit the required data to CMS. In aggregate, we estimate an annual burden of 44 hours (2 States x 22 hr/response) at a cost of $3,533 [2 States x ((20 hr x $77.25/hr) + (2 hr x $110.82/hr))].

C. Summary of Proposed Requirements and Annual Burden Estimates

Section under Title 42 of the CFR	OMB Control No. (CMS ID No.)	# of Respondents	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Cost ($/hr)	Total Cost ($)
600.610	0938-1218 (CMS-10510)	2	8	Varies	96	Varies	7,953
600.610	0938-1218 (CMS-10510)	2	8	Varies	880	Varies	70,666
600.610	0938-1218 (CMS-10510)	2	2	Varies	44	Varies	3,533
TOTAL		**2**	**18**	**Varies**	**1,020**	**Varies**	**82,152**

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements and burden. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit the CMS website at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRAListing, or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you comment, please submit your comments electronically as specified in the DATES and ADDRESSES sections of this proposed rule.

V. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

Section 1331 of the ACA (42 U.S.C. 18051) requires the Secretary to establish a BHP, and section 1331(d)(1) specifically provides that if the Secretary finds that a State meets the requirements of the program established under section 1331(a) of the ACA, the Secretary shall transfer to the State Federal BHP payments described in section 1331(d)(3) of the ACA. This proposed methodology provides for the funding methodology to determine the Federal BHP payment amounts required to implement these provisions for program year 2023.

B. Overall Impact

We have examined the impacts of this rule as required by E.O. 12866 on Regulatory Planning and Review (September 30, 1993), E.O. 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), E.O. 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches

that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) (having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is "economically significant" as measured by the $100 million threshold. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

The aggregate economic impact of this proposed payment methodology is estimated to be $357 million in transfers for calendar years (CY) 2022 and 2023 (measured in real 2022 dollars), which would be an increase in Federal payments to the State BHPs. For the purposes of this analysis, we have assumed that two States would implement BHPs in 2023. This assumption is based on the fact that two States have established a BHP to date, and we do not have any indication that additional States may implement a BHP in CY 2023. Of these two States, only one (Minnesota) currently has an approved section 1332 waiver.

Projected BHP enrollment and expenditures under the previous payment methodology

were calculated using the most recent 2022 QHP premiums and State estimates for BHP enrollment. We projected enrollment for 2023 using the projected increase in the number of adults in the U.S. from 2022 to 2023 (0.4 percent), and we projected premiums using the NHE projection of premiums for private health insurance (4.6 percent). Prior to any changes made in the 2023 BHP payment methodology, Federal BHP expenditures are projected to be $8,340 million in 2023, which are described in detail below. This projection serves as our baseline scenario when estimating the net impact of the 2023 proposed methodology on Federal BHP expenditures.

The incorporation of the WF is the most significant change in this proposed methodology from the final 2022 payment methodology. To calculate the impact of adding the WF to the methodology, we took the following steps. First, we calculated the estimated value of the WF using the most recently available section 1332 waiver premium data for 2021.[29] In Minnesota, the average percentage difference between the "with waiver" SLCSP premiums and the "without waiver" SLCSP premiums for 2021 is 27.3 percent (calculated as the average of the "without waiver" SLCSP premium divided by the "with waiver" SLCSP premium, averaged across all rating areas). We then increased the RPs in the model for Minnesota by 27.3 percent, which represents the impact of the WF. The resulting Federal BHP payments were 28.2 percent higher incorporating this adjustment. The projected BHP expenditures after these changes are $8,154 million, which is the sum of the prior estimate ($8,021 million) and the impacts of the changes to the methodology ($133 million). For Minnesota, estimated payments would increase from $470 million to $603 million in 2023.

---

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-State-Specific-Premium-Data-Feb-2021.xlsx.

TABLE 2: Estimated Federal Impacts for the Basic Health Program 2023 Payment Methodology to Add Waiver Factor [Millions of 2022 dollars]

Projected Federal BHP Payments under 2022 Final Methodology	$8,021
Projected Federal BHP Payment under 2023 Proposed Methodology	$8,154
Federal costs	$133

Totals may not add due to rounding.

The provisions of this proposed methodology are designed to determine the amount of funds that will be transferred to States offering coverage through a BHP rather than to individuals eligible for Federal financial assistance for coverage purchased on the Exchange. We are uncertain what the total Federal BHP payment amounts to States will be as these amounts will vary from State to State due to the State-specific factors and conditions. In this case, the exact value of the WF and the effects of the section 1332 waiver in 2023 are currently unknown. The value of the WF could be higher or lower than estimated here as a result. In addition, projected BHP expenditures and enrollment may also differ from our current estimates, which may also lead to costs being higher or lower than estimated here.

In addition, the proposed methodology would allow for a retrospective correction to the BHP payment methodology for errors that occurred during the development or application of the BHP funding methodology. For 2019, we propose to correct the value of the IRF from 98.03 percent to 102.01 percent. Actual Federal BHP expenditures in 2019 were $5,591 million, including payment reconciliations that have occurred as of March 2022. Calculating the payments with the corrected IRF value increases the payments by about $224 million. The actual amount may differ as we continue to reconcile 2019 payments based on actual enrollment.

TABLE 3: Estimated Federal Impacts for the Basic Health Program 2023 Payment Methodology to Apply Retrospective Corrections [Millions of 2022 dollars]

Actual Federal BHP Payment (2019)	$5,591
Projected Federal BHP Payment with Correction (2019)	$5,815
Federal costs	$224

Totals may not add due to rounding.

The total estimated impact of this proposed methodology is $357 million ($133 million

for the addition of the section 1332 waiver factor, and $224 million for the correction to the income reconciliation factor for 2019).

D. Alternative Approaches

We considered several alternatives in developing the BHP payment methodology for 2023, and we discuss some of these alternatives below.

We considered alternatives as to how to calculate the PAF in the final methodology for 2023. The value for the PAF is 1.188, which is the same as was used for 2018, 2019, 2020, 2021, and 2022. We believe it would be difficult to obtain the updated information from QHP issuers comparable to what was used to develop the 2018 factor, because QHP issuers may not distinctly consider the impact of the discontinuance of CSR payments on the QHP premiums any longer. We do not have reason to believe that the value of the PAF would change significantly between program years 2018 and 2023. We are continuing to consider whether or not there are other methodologies or data sources we may be able to use to calculate the PAF.

We also considered whether to continue to provide States the option to develop a protocol for a retrospective adjustment to the PHF as we did in previous payment methodologies. We believe that continuing to provide this option is appropriate and likely to improve the accuracy of the final payments.

We also considered whether to require the use of the program year premiums to develop the Federal BHP payment rates, rather than allow the choice between the program year premiums and the prior year premiums trended forward. We believe that the payment rates can still be developed accurately using either the prior year QHP premiums or the current program year premiums and that it is appropriate to continue to provide the States these options.

We also considered whether or not to include a factor to address the impacts of State Innovation Waivers. In previous methodologies, we have not addressed the potential impacts of State Innovation Waivers on BHP payments. We believe it is appropriate to include such a factor for this payment methodology. We also considered other approaches to calculating the factor,

including whether or not to use each State's experience separately or to look at the impacts across all States. We believe it is more accurate to use each State's experience separately, as applicable.

Many of the factors in the final methodology are specified in statute; therefore, for these factors we are limited in the alternative approaches we could consider. We do have some choices in selecting the data sources used to determine the factors included in the methodology. We will continue to use national rather than State-specific data, with the exception of State-specific RPs and enrollment data. This is due to the lack of currently available State-specific data needed to develop the majority of the factors included in the methodology. We believe the national data will produce sufficiently accurate determinations of payment rates. In addition, we believe that this approach will be less burdensome on States. In many cases, using State-specific data would necessitate additional requirements on the States to collect, validate, and report data to CMS. By using national data, we are able to collect data from other sources and limit the burden placed on the States. For RPs and enrollment data, we will use State-specific data rather than national data, as we believe State-specific data will produce more accurate determinations than national averages.

E. Accounting Statement and Table

TABLE 4: Accounting Statement: Federal Transfers to States
[$ millions]

Category	Primary estimate	Low estimate	High Estimate	Units		
				Year dollars	Discount rate	Period covered
Annualized Monetized Transfers from Federal Government to States	$180	$163	$197	2022	7%	2022-2023
	$179	$162	$196	2022	3%	2022-2023

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), we have prepared an accounting statement in Table 4 showing the classification of the transfer payments from the Federal

government to States associated with the provisions of this proposed rule. Table 4 provides our best estimates of the transfer payments outlined in the section C. Detailed Economic Analysis above. These estimates assume that costs in 2022 could be 5 percent above and below the primary estimate ($224 million in 2022 dollars) and that costs in 2023 could be 18 percent above and below the primary estimate ($133 million in 2022 dollars, which reflects a waiver factor that could be 5 percentage points higher or lower than assumed in the analysis).

F. Regulatory Flexibility Act (RFA)

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that no small entities will be impacted as that term is used in the RFA (include small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million). Individuals and States are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the requirements in this proposed rule.

Because this methodology is focused solely on Federal BHP payment rates to States, it does not contain provisions that would have a direct impact on hospitals, physicians, and other health care providers that are designated as small entities under the RFA. Accordingly, we have determined that the methodology, like the previous methodology and the final rule that established the BHP program, will not have a significant economic impact on a substantial number of small entities. Therefore, the Secretary has determined that this rule will not have a significant economic impact on a substantial number of small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a

methodology may have a significant economic impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. For the preceding reasons, we have determined that the methodology will not have a significant impact on a substantial number of small rural hospitals. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 2005 (Pub. L. 104-4) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by State, local, or tribal governments, in the aggregate, or by the private sector. In 2022, that threshold is approximately $165 million. States have the option, but are not required, to establish a BHP. Further, the methodology would establish Federal payment rates without requiring States to provide the Secretary with any data not already required by other provisions of the ACA or its implementing regulations. Thus, neither the current nor the proposed payment methodologies mandate expenditures by State governments, local governments, or tribal governments.

H. Federalism

E.O. 13132 establishes certain requirements that an agency must meet when it issues a final rule that imposes substantial direct effects on States, preempts State law, or otherwise has Federalism implications. The BHP is entirely optional for States, and if implemented in a State, provides access to a pool of funding that would not otherwise be available to the State. Accordingly, the requirements of E.O. 13132 do not apply to this proposed rule.

I. Conclusion

We believe that this proposed BHP payment methodology is effectively the same methodology as finalized for 2022, with the exception of the addition of the WF. In addition, we propose to update the regulation to clarify that errors in the application and the development of the methodology may be corrected retroactively. BHP payment rates may change as the values of the factors change, most notably the QHP premiums for 2022 or 2023. We do not anticipate this proposed methodology to have any significant effect on BHP enrollment in 2023.

In accordance with the provisions of E.O. 12866, this regulation was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on May 13, 2022.

List of Subjects in 42 CFR part 600

Administrative practice and procedure, Health care, health insurance, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 600 as set forth below:

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILIATION.

1. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, 124 Stat 1029).

2. Amend § 600.610—

a. By revising paragraphs (a)(1) and (b)(1); and

b. In paragraph (c)(2)(ii), by removing the phrase "during the application of the BHP funding methodology" and adding in its place the phrase "during the application or development of the BHP funding methodology".

The revisions read as follows:

§ 600.610 Secretarial determination of BHP payment amount.

(a) * * *

(1) Beginning in FY 2015, the Secretary will determine and publish in a **Federal Register** document the BHP payment methodology for the next calendar year, or for multiple calendar years beginning in calendar year 2022, as determined by the Secretary. Beginning in calendar year 2023, in years in which the Secretary does not publish a new BHP methodology, the Secretary will update the values of factors needed to calculate the Federal BHP payments via subregulatory guidance, as appropriate. Beginning in calendar year 2023, in years that the Secretary publishes a revised payment methodology, the Secretary will publish a proposed BHP payment methodology upon receiving certification from the Chief Actuary of CMS.

* * * * *

(b) * * *

(1) Beginning in calendar year 2023, in years that the Secretary publishes a revised payment methodology, the Secretary will determine and publish the final BHP payment methodology and BHP payment amounts in a **Federal Register** document.

* * * * *

Dated: May 18, 2022.

Xavier Becerra,

Secretary,

Department of Health and Human Services.

[FR Doc. 2022-11047 Filed: 5/23/2022 11:15 am; Publication Date: 5/25/2022]